(PCI) evaluations may predict the precise technique indication. A posterior organ approach allows access to the splenocolic, splenophrenic, and splenorenal ligaments, which are identified and divided. Ligation of the short gastric vessels can be achieved with metallic clips or silk stitches. During a total resection due to parenchymal metastasis, dissection of the splenic hilum with ligation of the splenic artery followed by the splenic vein. We demonstrate two other cases with partial/capsular splenectomy with electrocautery and/or cold blade. Temporary clipping of the splenic vessels may be necessary for extended partial splenectomies, and will be described in another video.

**Conclusion/Implications** This video demonstrates reproducible standardized techniques for total or partial splenectomy in ovarian cancer cytoreduction.

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**SF039/#1171 LAPAROSCOPIC POSTERIOR INFERIOR MEDIASTINAL PRONE POSITION LYMPHADENECTOMY FOR RECURRENT GYNECOLOGIC CARCINOMA**

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**Introduction** There is a potential oncological benefit related to isolated recurrences surgical resection. The aim of this video is to demonstrate a prone position laparoscopic approach to posterior inferior mediastinal lymphadenectomy.

**Description** The patient had been treated for a pelvic gynecologic poorly differentiated carcinoma with a sarcomatoid component, 4 years before this salvage procedure. She had received a pelvic lymphadenectomy and a total hysterectomy. Her nodal recurrence was detected during follow-up and partially responded to platin-based chemotherapy. After a multidisciplinary discussion, surgical resection was offered. The patient was in a prone position, similar to the thoracic step for esophagectomy. Selective ventilation was followed by right side access (4 trocars). An anatomical review was performed as the pleural space was entered and the right lung collapsed with right selective ventilation. The dissection started with a mediastinal pleural dissection with regular bipolar and advanced bipolar, proximal to distal, from T10 to T12, between the thoracic aorta and the corpus vertebrae. Intercostal branches and azygos vein were preserved. All small vascular and lymphatic branches were sealed and/or clipped. The specimen was inserted into a bag and retrieved by the 12 mm incision. A thoracic drain was placed. Surgical time was 96 min, blood loss 12cc. Thoracic drain was retrieved on POD2 when the patient was discharged.

**Conclusion/Implications** The laparoscopic prone surgical approach is safe, feasible, and standardized for the thoracic/upper digestive surgeon, and should be considered for posterior mediastinal approaches. *This video was presented at AAGL 2021 annual meeting.

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**SF040/#1096 RADICAL LEFT HEMIVULVECTOMY, SUPERFICIAL RIGHT HEMIVULVECTOMY AND SENTINEL LYMPH NODE WITH INDOCYANINE GREEN**

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**Introduction** Vulvar cancer accounts for 3–5% of malignant diseases of the female genital tract. The surgical management remains complex, because it can concern two types of patients, on the one hand elderly patients with heavy comorbidities, on the other hand younger patients with a high risk of alteration of the quality of life and sexuality.

**Description** We present the case of a 68-year-old woman, treated for a 20 mm squamous cell carcinoma of left hemivulva and high-grade vulvar intraepithelial neoplasia of left and right labia minora and clitoris. This patient is eligible for a sentinel node procedure. This surgical film shows a left radical hemivulvectomy, a right superficial hemivulvectomy and identification of bilateral sentinel lymph node with indocyanine green.

**Conclusion/Implications** Improvements like sentinel lymph node procedure in treatment of vulvar cancer contribute to the decrease of mortality and morbidity. The possibility of performing a hemivulvectomy also allows to reduce the consequences of vulvar surgery in a de-escalation strategy.

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**SF041/#1128 ROBOT-ASSISTED RADICAL COLPOMETRECTOMY IN VAGINAL CANCER**

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**Introduction** Vaginal cancer is rare, and robotic-assisted surgical treatment is an exploratory field. The objective of this case report is to describe the robotic technique and the oncological results of a 37-year-old patient, two gravida two deliveries, who underwent a simple hysterectomy due to a persistent high-grade cervical lesion.

**Description** Three years later, she presented a high-posterior vaginal wall nodule. The colposcopy-guided biopsy revealed squamous cell carcinoma, while the MRI showed a 4.6 cm mass with no suspicious pelvic lymph nodes or lateral